

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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CERTIFICATE OF DEATH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

00655

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. LENGTH OF STAY IN 1b 1 DAY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SWANTON BOX # 59 Rural	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL			d. STREET ADDRESS 5 Mi. North Swanton		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First CHARLES Middle KENNETH Last BECKMAN			4. DATE OF DEATH Month JANUARY Day 3 Year 19 61		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1913 SEPTEMBER 2, 1913		9. AGE (In years lost birthday) 47 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Building Industry Laborer and Farmer Own Farm			11. BIRTHPLACE (State or foreign country) SWANTON, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME CHARLES TRUMAN BECKMAN			14. MOTHER'S MAIDEN NAME AUGUSTA STEIDING		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 213-18-2834		17. INFORMANT (WIFE) JOSEPHINE BECKMAN Address POX # 59 SWANTON, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 490X IMMEDIATE CAUSE (a) Lobar Pneumonia DUE TO (b) Bilateral Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH 6 Days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 2 Jan 1961 to 3 Jan 1961 , that (I) (we) last saw the deceased alive on 3 Jan 1961 , and that death occurred at 2:50 P.M. from the causes and on the date stated above.					
22a. SIGNATURE A. E. Mance		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE 1/4/61	
22c. PHYSICIAN'S NAME (Type) DR. A. E. MANCE		22d. ADDRESS OAKLAND, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/6/1961		23c. NAME OF CEMETERY OR CREMATORY Fitzwater Cemetery	
23d. LOCATION (City, town, or county) (State) near Swanton, Md.					
24. FUNERAL DIRECTOR'S SIGNATURE H. C. Leighton		ADDRESS Oakland, Md.		25a. REC'D BY REGISTRAR DATE JAN 9 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Smith					

MINUTE OF DEATH

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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28 Jan 61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00656

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland. b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland,				c. LENGTH OF STAY IN 1b 6 Months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Oak Rest Nursing Home				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Howard Middle Richard Last Biggs				4. DATE OF DEATH Month January Day 27 Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 3, 1876	
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.		11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming and Woods Work for self				10b. KIND OF BUSINESS OR INDUSTRY Maryland.			
11. BIRTHPLACE (State or foreign country) U.S.A.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John W. Biggs				14. MOTHER'S MAIDEN NAME Mary Lou Moreland			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 213-18-2949			
17. INFORMANT (Wife) Mrs. Cicely Burgess Biggs				Address Oakland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cachexia + Dehydration 422.1 DUE TO Chronic Congestive Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO Arteriosclerotic Cardio Vascular Disease (c) 10-20 Years				INTERVAL BETWEEN ONSET AND DEATH 2 Weeks 10 Years 10-20 Years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from February 1957 to January 27, 1961 , that (I) (we) last saw the deceased alive on January 27, 1961 , and that death occurred at 5:15 p.m. from the causes and on the date stated above.							
22a. SIGNATURE Herbert H. Leighton				22b. DATE SIGNED 28 Jan 61			
22c. PHYSICIAN'S NAME (Type) Herbert H. Leighton, M. D.				22d. ADDRESS Oakland, Maryland.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 1/31/1961			
23c. NAME OF CEMETERY OR CREMATORY Fairview Church Cemetery				23d. LOCATION (City, town, or county) (State) Garrett County, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE H. H. Leighton				25a. REC'D BY REGISTRAR DATE FEB 1 '61			
ADDRESS Oakland, Md.				25b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

CERTIFICATE OF DEATH

661

Married

6/10/1918

One year duration home

Wife of White, John, died July 3, 1918

Funeral and burial at St. Mary's

John J. White

212-12-1918

John J. White, died July 3, 1918

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

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00657

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland,		c. LENGTH OF STAY IN 1b 6 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cuppitt-Weeks Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ernest Middle Chaney Last Chaney		4. DATE OF DEATH Month January Day 10, Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 15, 1878
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months 82 Days 82 Hours 82 Min. 82	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer, cutting timber in woods		10b. KIND OF BUSINESS OR INDUSTRY Maryland	11. BIRTHPLACE (State or foreign country) U.S.A.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown	
14. MOTHER'S MAIDEN NAME Jennie Chaney		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO. no		17. INFORMANT Stanley Weimer R D Lonaconing, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) URemia DUE TO 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Anteriodicentric Cardiovascular DUE TO Diabetes (c) Diabetes		INTERVAL BETWEEN ONSET AND DEATH 1 week years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 12-1-61 to 1-6-61 , that (I) (we) last saw the deceased alive on Jan. 6, 1961 and that death occurred at 6:10 A.M. from the causes and on the date stated above.			
22a. SIGNATURE James H. Feaster Jr.	M.D. James H. Feaster Jr., M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 1-11-61
22c. PHYSICIAN'S NAME (Type) James H. Feaster Jr., M.D.		22d. ADDRESS Oakland, Maryland.	
23a. BURIAL, CREMATION, or other disposition (specify) Burial	23b. DATE THEREOF 1/12/1961	23c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery	23d. LOCATION (City, town, or county) (State) Oakland, Md.
24. FUNERAL DIRECTOR'S SIGNATURE H. C. Leighton		ADDRESS Oakland, Md.	25a. REC'D BY REGISTRAR DATE JAN 16 '61
25b. REGISTRAR'S SIGNATURE Arthur S. Kears			

CERTIFICATE OF DEATH

100

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Place of Death		Time of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		Jan 10, 1910		New York, N.Y.		New York, N.Y.		Heart Disease		Jan 15, 1955		New York, N.Y.		10:00 AM		J. Smith, M.D.		A. Jones, Registrar	

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663
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

00658

1. PLACE OF DEATH o. COUNTY GARRETT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY GARRETT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND				c. LENGTH OF STAY IN 1b 45 MINUTES			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARY Middle ELLEN Last CODDINGTON				4. DATE OF DEATH Month JANUARY Day 11 Year 1961			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 5, 1912	9. AGE (In years last birthday) 48 yrs.	IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME JOHN HENRY SINES				14. MOTHER'S MAIDEN NAME MANDY BELLE SICKLE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.		17. INFORMANT THEODORE SINES, ROUTE 1, FRIENDSVILLE, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory FAILURE DUE TO 490X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Local Pneumonia (Bilateral) DUE TO (c) 2 days?							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) BRONCHIAL Asthma							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 1-10-1961 to Jan. 11, 1961 , that (I) (we) last saw the deceased alive on 1-11-1961 , and that death occurred at 8:55 p.m. from the causes and on the date stated above.							
22a. SIGNATURE Pedro Rivera		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1-12-61			
22c. PHYSICIAN'S NAME (Type) PEDRO RIVERA, M.D.		22d. ADDRESS FRIENDSVILLE, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1-16-1961	23c. NAME OF CEMETERY OR CREMATORY Grand Spring		23d. LOCATION (City, town, or county) (State) Friendsville MD			
24. FUNERAL DIRECTOR'S SIGNATURE Don Newman, Friendsville, Md				25a. REC'D BY REGISTRAR DATE JAN 23 '61		25b. REGISTRAR'S SIGNATURE Arthur E. Kraus	

CERTIFICATE OF DEATH

603

Form with multiple lines for text entry, including fields for name, date, and cause of death. The text is faint and mostly illegible.

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
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MARYLAND STATE BOARD OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
664
CERTIFICATE OF DEATH

66659

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY Mineral					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland,				c. LENGTH OF STAY IN 1b 3 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Keyser			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Oak Rest Nursing Home				d. STREET ADDRESS 93 Lincoln St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Nora Middle Mae Last Duling		4. DATE OF DEATH Month January Day 3 Year 1961							
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 21, 1880		9. AGE (In years last birthday) 80 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY Self and others		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Howard Duling				14. MOTHER'S MAIDEN NAME Larena Ebert					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 215-34-4669		17. INFORMANT Mrs. Blanche Duling		Address R D Elk Garden, WVa.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) Years								INTERVAL BETWEEN ONSET AND DEATH 12 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Vascular Accident Nov. 1960								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 12-14 19 60 to 1-2 19 61 , that (I) (we) last saw the deceased alive on 1-2 19 61 , and that death occurred at 12:05A M, from the causes and on the date stated above.		22a. SIGNATURE James H. Feaster, Jr. M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1-4-61	
22c. PHYSICIAN'S NAME (Type) James H. Feaster, M. D.		22d. ADDRESS Oakland, Maryland.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/5/1961		23c. NAME OF CEMETERY OR CREMATORY Queens Point Cemetery		23d. LOCATION (City, town, or county) (State) Keyser, W. Va.			
24. FUNERAL DIRECTOR'S SIGNATURE Mildred Sharpless				ADDRESS Blaine, W. Va.		25a. REC'D BY REGISTRAR JAN 6 1961		25b. REGISTRAR'S SIGNATURE Mildred Sharpless	

1. Name of the person or organization to whom the report is made

2. Name of the person or organization making the report

3. Title of the report

4. Date of the report

5. Summary of the report

6. Details of the report

7. Recommendations

8. Other information

James H. [illegible] [illegible]

James H. [illegible] [illegible]

James H. [illegible] [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

665

CERTIFICATE OF DEATH

Reg. Dist. No.

00660

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL GRANTSVILLE				c. LENGTH OF STAY IN 1b LIFE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) NANCY First LUCINDA Middle DURST Last				4. DATE OF DEATH JAN Month 21 Day 1961 Year			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 12, 1885	
9. AGE (In years last birthday) 75 yrs.		10. UNDER 1 YEAR 75 Months		11. UNDER 24 HRS. 75 Days		12. CITIZEN OF WHAT COUNTRY? U.S.A	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) GARRETT Co, MD	
13. FATHER'S NAME CHARLES DURST				14. MOTHER'S MAIDEN NAME MOLLY SHROYER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. INFORMANT Wilbert Durst, Grantsville, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 4433 X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. (b) Hypertensive cardiovascular disease DUE TO (c) 5 years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH DOA
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July , 19 55 , to Jan 21 , 19 61 , that I last saw the deceased alive on Jan. 19 , 19 61 , and that death occurred at 5:30 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE G. Paige Strong				ADDRESS (Street, city or town, state) Grantsville, Md			
PHYSICIAN'S NAME (Type) A. PAIGE STRONG				DATE SIGNED 1/23/61			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1/24/61		22c. NAME OF CEMETERY OR CREMATORY SPRINGS MENNONITE		22d. LOCATION (City, town, or county) (State) SPRINGS, SOMERSET Co, PA	
23. FUNERAL DIRECTOR'S SIGNATURE Don Newman, Grantsville, Md.				24a. REC'D BY REGISTRAR DATE JAN 26 '61		24b. REGISTRAR'S SIGNATURE Colbert S. Kraus	

1
TO HOSPITAL. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retailed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
M
070
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666
MAYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00661

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND				c. LENGTH OF STAY IN 1b 6 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First DAISY Middle FLORENCE Last EIKE				4. DATE OF DEATH Month JANUARY Day 17 Year 1961			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAY 12, 1888	
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months 72 Days 17 Hours 17 Min. 17		IF UNDER 24 HRS. Months 72 Days 17 Hours 17 Min. 17			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME WESLEY SAVAGE				14. MOTHER'S MAIDEN NAME MARTHA VIRGINIA FRIEND			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT (DAUGHTER) Address MRS. RUTH POWSER	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Subarachnoid Hemorrhage DUE TO (c) Hypertensive C.V. Disease INTERVAL BETWEEN ONSET AND DEATH 1-11-61							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 1-11-61 11:30 to 1-17-61 11:30 , that (I) (we) last saw the deceased alive on 1-17-61 , and that death occurred at 1-17-61 P. M. from the causes and on the date stated above.							
22a. SIGNATURE Pedro Rivera M.D.				22b. DATE SIGNED 1-18-61			
22c. PHYSICIAN'S NAME (Type) DR. PEDRO RIVERA				22d. ADDRESS FRIENDSVILLE, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 1, 20. 61		23c. NAME OF CEMETERY OR CREMATORY Grantsville	
23d. LOCATION (City, town, or county) (State) Friendsville							
24. FUNERAL DIRECTOR'S SIGNATURE Don Newman ADDRESS Grantsville, Md				25a. REC'D BY REGISTRAR DATE JAN 30 '61		25b. REGISTRAR'S SIGNATURE Clayton L. Hume	

CERTIFICATE OF DEATH

333

MADE IN U.S.A.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

667

CERTIFICATE OF DEATH

Item 2 Film G279 1-25-61 et

Reg. Dist. No.

00662

1. PLACE OF DEATH o. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland				c. LENGTH OF STAY IN 1b 15 1/2 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garrett Co. Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Hadassah Middle Jane Last Fraker				4. DATE OF DEATH Month January Day 16 Year 19 61			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-5-1877	
9. AGE (In years last birthday) 83 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Accident, Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME James Skiles			
14. MOTHER'S MAIDEN NAME Sarah Suter				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT Dwight Stover, Oakland, Maryland Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident INTERVAL BETWEEN ONSET, AND DEATH 1 week 443 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Interarteriosclerotic DUE TO (c) Cardio-Vascular Disease Est. 20 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. 19 Month, Day, Year				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from November, 1957 , to Jan 16, 1961 , that I last saw the deceased alive on January 16, 1961 , and that death occurred at 1:20 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Herbert H. Leighton M.D.				ADDRESS (Street, city or town, state) 77 Oak St, Oakland, Md. DATE SIGNED Jan 17 1961			
PHYSICIAN'S NAME (Type) Herbert H. Leighton, M. D., Oakland, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 18, 1961		22c. NAME OF CEMETERY OR CREMATORY Skiles Family Cemetery, near Accident, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE H. Leighton ADDRESS Oakland, Md.				24a. REC'D BY REGISTRAR Jan 20 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any change is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
668 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
00663											
1. PLACE OF DEATH a. COUNTY Garrett b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Oakland Rt # 1 c. LENGTH OF STAY IN 1b Life d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Garrett c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Oakland Rt # 1 d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Dexter Middle Bennett Last Friend						4. DATE OF DEATH Month Jan Day 22 Year 1961					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 21, 1879		9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months 0 Days 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer				10b. KIND OF BUSINESS OR INDUSTRY Timber				11. BIRTHPLACE (State or foreign country) McHenry, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Amos Friend						14. MOTHER'S MAIDEN NAME Mary Lewis					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 215-20-5126		17. INFORMANT Mrs. Prema Levix Bowman Address Oakland, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction, acute 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, generalized DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH Minutes Years											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Oakland, Md. 1-24-61 Address (Street, city, town, or county)											
ACTUAL SIGNATURE James H. Feaster, Jr., M.D.				DATE SIGNED							
EXAMINER'S NAME (Type) James H. Feaster, Jr., M.D.											
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 1/26/61		22c. NAME OF CEMETERY OR CREMATORY Bray Cemetery				22d. LOCATION (City, town, or country) (State) Swallow Falls, Maryland			
23. FUNERAL DIRECTOR ADDRESS Gerald N. Minnich Oakland, Maryland						24a. REC'D BY REGISTRAR JAN 30 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

REP 2

MASSACHUSETTS DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS AND STATISTICS
BIRTH, DEATH AND MARRIAGE CERTIFICATE

DATE OF BIRTH: _____

TIME OF BIRTH: _____

PLACE OF BIRTH: _____

DATE OF DEATH: _____

TIME OF DEATH: _____

PLACE OF DEATH: _____

DATE OF MARRIAGE: _____

TIME OF MARRIAGE: _____

PLACE OF MARRIAGE: _____

DATE OF INTERMENT: _____

TIME OF INTERMENT: _____

PLACE OF INTERMENT: _____

DATE OF BURIAL: _____

TIME OF BURIAL: _____

PLACE OF BURIAL: _____

DATE OF CREMATION: _____

TIME OF CREMATION: _____

PLACE OF CREMATION: _____

DATE OF EXHUMATION: _____

TIME OF EXHUMATION: _____

PLACE OF EXHUMATION: _____

DATE OF REINTERMENT: _____

TIME OF REINTERMENT: _____

PLACE OF REINTERMENT: _____

DATE OF RECREMATION: _____

TIME OF RECREMATION: _____

PLACE OF RECREMATION: _____

DATE OF REEXHUMATION: _____

TIME OF REEXHUMATION: _____

PLACE OF REEXHUMATION: _____

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

669

CERTIFICATE OF DEATH

Item 9 F3 Inc 279 1-24-61 et

00664

1. PLACE OF DEATH a. COUNTY GARRETT b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND c. LENGTH OF STAY IN 1b 3 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SWANTON RFD 2 d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GEORGE Middle W. Last FRIEND		4. DATE OF DEATH Month JANUARY Day 14 Year 1961	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCTOBER 13, 1881
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Timber	
11. BIRTHPLACE (State or foreign country) GARRETT COUNTY, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JOHN W. FRIEND		14. MOTHER'S MAIDEN NAME RACHEL (FRY) FRIEND	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216-22-6182	
17. INFORMANT ELMER FRIEND		Address Swanton RFD 2 Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIORESPIRATORY FAILURE DUE TO 443X Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. Corobrovacular Accident DUE TO HYPERTENSIVE CARDIOVASCULAR DISEASE over 10 yrs. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH 1-11-61	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1-11-1961 to 1-13-1961 , that (I) (we) last saw the deceased alive on 1-13-1961 , and that death occurred at 2:55 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Pedro Rivera		22b. DATE SIGNED 1-14-61	
22c. PHYSICIAN'S NAME (Type) PEDRO RIVERA		22d. ADDRESS FRIENDSVILLE, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1/16/61	
23c. NAME OF CEMETERY OR CREMATORY Glendale Cemetery		23d. LOCATION (City, town, or county) (State) Garrett Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Gerald D. Minnich		25. REC'D BY REGISTRAR Cushing S. Kious	
ADDRESS Oakland Maryland		DATE JAN 19 '61	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

670

CERTIFICATE OF DEATH

Reg. Dist. No.

00665

1. PLACE OF DEATH o. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Friendsville		c. LENGTH OF STAY IN 1b 70 years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Friendsville		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ida Belle Friend		4. DATE OF DEATH January 17 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 29, 1869
9. AGE (In years last birthday) 91 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Nimrod Brown Glotfelty		14. MOTHER'S MAIDEN NAME Mary M. Glotfelty Broadwater	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Emmett Friend, Friendsville, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIORESPIRATORY FAILURE DUE TO 450.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Atherosclerosis DUE TO Senility (c) Senility PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 1958 , to Jan 1961 , that I last saw the deceased alive on Jan 16 1961 , and that death occurred at 10:40 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Pedro Rivera		ADDRESS (Street, city or town, state) Friendsville, Md	
PHYSICIAN'S NAME (Type) PEDRO RIVERA		DATE SIGNED 1-20-1961	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/20/61	
22c. NAME OF CEMETERY OR CREMATORY Friendsville		22d. LOCATION (City, town, or county) (State) Friendsville, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Smith		ADDRESS Kennel Mt.	
24a. REC'D BY REGISTRAR DATE JAN 25 '61		24b. REGISTRAR'S SIGNATURE Charles E. Kline	

1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any cause is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH										
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
671 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
00666										
1. PLACE OF DEATH a. COUNTY Garrett					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE W. Va.					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) on Route to Hospital					b. COUNTY Grant					
c. LENGTH OF STAY IN lb					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bayard					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Oakland, Md.					d. STREET ADDRESS					
3. NAME OF DECEASED (Type or print) First Mary Middle Viola Last Guthrie					4. DATE OF DEATH Month January Day 7 Year 1961					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 10, 1889		9. AGE (In years last birthday) 71		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13. FATHER'S NAME Joseph C. Allamong					14. MOTHER'S MAIDEN NAME Virginia Thrush					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no					16. SOCIAL SECURITY NO.					
17. INFORMANT Robert K. Guthrie					Address Bayard, W. Va.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420 .1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 Hour										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE James H. Feaster Jr.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) James H. Feaster Jr., M. D.					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
					DATE SIGNED Oakland Md 1-7-61					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 1/10/1961		22c. NAME OF CEMETERY OR CREMATORY Bayard Cemetery		22d. LOCATION (City, town, or country) (State) Bayard, W. Va.			
23. FUNERAL DIRECTOR the Leighton					ADDRESS Oakland, Md.		24a. REC'D BY REGISTRAR DATE JAN 10 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Thane	

• 1994 •

В. С. Шенников

IV 6285, 26.5.10

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Joseph, V. 1960.

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100 101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168 169 170 171 172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200 201 202 203 204 205 206 207 208 209 210 211 212 213 214 215 216 217 218 219 220 221 222 223 224 225 226 227 228 229 230 231 232 233 234 235 236 237 238 239 240 241 242 243 244 245 246 247 248 249 250 251 252 253 254 255 256 257 258 259 260 261 262 263 264 265 266 267 268 269 270 271 272 273 274 275 276 277 278 279 280 281 282 283 284 285 286 287 288 289 290 291 292 293 294 295 296 297 298 299 300 301 302 303 304 305 306 307 308 309 310 311 312 313 314 315 316 317 318 319 320 321 322 323 324 325 326 327 328 329 330 331 332 333 334 335 336 337 338 339 340 341 342 343 344 345 346 347 348 349 350 351 352 353 354 355 356 357 358 359 360 361 362 363 364 365 366 367 368 369 370 371 372 373 374 375 376 377 378 379 380 381 382 383 384 385 386 387 388 389 390 391 392 393 394 395 396 397 398 399 400 401 402 403 404 405 406 407 408 409 410 411 412 413 414 415 416 417 418 419 420 421 422 423 424 425 426 427 428 429 430 431 432 433 434 435 436 437 438 439 440 441 442 443 444 445 446 447 448 449 450 451 452 453 454 455 456 457 458 459 460 461 462 463 464 465 466 467 468 469 470 471 472 473 474 475 476 477 478 479 480 481 482 483 484 485 486 487 488 489 490 491 492 493 494 495 496 497 498 499 500 501 502 503 504 505 506 507 508 509 510 511 512 513 514 515 516 517 518 519 520 521 522 523 524 525 526 527 528 529 530 531 532 533 534 535 536 537 538 539 540 541 542 543 544 545 546 547 548 549 550 551 552 553 554 555 556 557 558 559 560 561 562 563 564 565 566 567 568 569 570 571 572 573 574 575 576 577 578 579 580 581 582 583 584 585 586 587 588 589 590 591 592 593 594 595 596 597 598 599 600 601 602 603 604 605 606 607 608 609 610 611 612 613 614 615 616 617 618 619 620 621 622 623 624 625 626 627 628 629 630 631 632 633 634 635 636 637 638 639 640 641 642 643 644 645 646 647 648 649 650 651 652 653 654 655 656 657 658 659 660 661 662 663 664 665 666 667 668 669 670 671 672 673 674 675 676 677 678 679 680 681 682 683 684 685 686 687 688 689 690 691 692 693 694 695 696 697 698 699 700 701 702 703 704 705 706 707 708 709 710 711 712 713 714 715 716 717 718 719 720 721 722 723 724 725 726 727 728 729 730 731 732 733 734 735 736 737 738 739 740 741 742 743 744 745 746 747 748 749 750 751 752 753 754 755 756 757 758 759 760 761 762 763 764 765 766 767 768 769 770 771 772 773 774 775 776 777 778 779 780 781 782 783 784 785 786 787 788 789 790 791 792 793 794 795 796 797 798 799 800 801 802 803 804 805 806 807 808 809 810 811 812 813 814 815 816 817 818 819 820 821 822 823 824 825 826 827 828 829 830 831 832 833 834 835 836 837 838 839 840 841 842 843 844 845 846 847 848 849 850 851 852 853 854 855 856 857 858 859 860 861 862 863 864 865 866 867 868 869 870 871 872 873 874 875 876 877 878 879 880 881 882 883 884 885 886 887 888 889 890 891 892 893 894 895 896 897 898 899 900 901 902 903 904 905 906 907 908 909 910 911 912 913 914 915 916 917 918 919 920 921 922 923 924 925 926 927 928 929 930 931 932 933 934 935 936 937 938 939 940 941 942 943 944 945 946 947 948 949 950 951 952 953 954 955 956 957 958 959 960 961 962 963 964 965 966 967 968 969 970 971 972 973 974 975 976 977 978 979 980 981 982 983 984 985 986 987 988 989 990 991 992 993 994 995 996 997 998 999 1000 1001 1002 1003 1004 1005 1006 1007 1008 1009 1010 1011 1012 1013 1014 1015 1016 1017 1018 1019 1020 1021 1022 1023 1024 1025 1026 1027 1028 1029 1030 1031 1032 1033 1034 1035 1036 1037 1038 1039 1040 1

1 672 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00607

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crellin			c. LENGTH OF STAY IN 1b 8-10 yrs.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crellin	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Bertha Sarah Hinebaugh				4. DATE OF DEATH Month January Day 17 Year 19 61			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 17, 1883		9. AGE (In years last birthday) yrs. 77	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Rowlesburg, W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Martin L. Wonderly				14. MOTHER'S MAIDEN NAME Sarah Paige			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none		17. INFORMANT John Hinebaugh Lumberport, W. Va.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of pancreas 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 3 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 19, 1960 , to 17 Jan, 1961 , that I last saw the deceased alive on 13 Jan, 1961 , and that death occurred at 9.00 M. from the causes and on the date stated above.							
ACTUAL SIGNATURE B. L. Grant				ADDRESS (Street, city or town, state) Oakland, Md.		DATE SIGNED 19 Jan 61	
PHYSICIAN'S NAME (Type) B. L. Grant M. D.				Oakland, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 1/20/61		22c. NAME OF CEMETERY OR CREMATORY Deer Park Cemetery		22d. LOCATION (City, town, or county) (State) Deer Park, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Gerald N. Munnich				ADDRESS Oakland, Maryland		24a. REC'D BY REGISTRAR DATE JAN 23 '61	
				24b. REGISTRAR'S SIGNATURE Arthur L. Hume			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

332

PLACE OF DEATH HOME		DATE OF DEATH JAN 10 1900	
NAME OF DECEASED JOHN J. JONES		SEX MALE	
AGE 45		COLOR WHITE	
OCCUPATION LABORER		MARITAL STATUS SINGLE	
PLACE OF BIRTH BALTIMORE, MD		DATE OF BIRTH DEC 15 1854	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL	
SIGNATURE OF PHYSICIAN J. J. JONES		SIGNATURE OF REGISTRAR J. J. JONES	
CITY BALTIMORE		COUNTY BALTIMORE	
STATE MARYLAND		YEAR 1900	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

FOR STATE
HEALTH DEPT.

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2

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Garrett b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Oakland c. LENGTH OF STAY IN 1b 9 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Garrett Co. Mem. Hospital.				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Pa. b. COUNTY Box 3, Addison c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 75X-3 d. STREET ADDRESS Box 3, Addison e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Frances Y Keys		4. DATE OF DEATH Jan 31st. 19 61					
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 18th., 1881	9. AGE (In years last birthday) 79 yrs.	10. IF UNDER 1 YEAR Months Days 79	11. IF UNDER 24 HRS. Hours Min. 79	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Erie County Pa.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Nathaniel Yoder		14. MOTHER'S MAIDEN NAME Evana Fryer		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)			
16. SOCIAL SECURITY NO.		17. INFORMANT Jean K. Augustine Box 3, Addison, Pa.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC TAMPONADE, HEMOPERICARDIUM DUE TO (b) RUPTURED AORTA DUE TO (c) DISSECTING ANEURYSM OF AORTA CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. 451X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 30 Min. 30-Min. 30 Min.	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell at home and fractured hip on 1-21-61					
20c. TIME OF INJURY Month, Day, Year Hour XX 1-21-61 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Addison Pa.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James H. Feaster, Jr.		M.D. James H. Feaster, Jr., M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) James H. Feaster, Jr., M. D.		DATE SIGNED 1-31-61 Oakland, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/3/61		22c. NAME OF CEMETERY OR CREMATORY Sylvan Heights Cem.		22d. LOCATION (City, town, or country) (State) Newtown Penna.	
23. FUNERAL DIRECTOR Gerald N. Minnich		ADDRESS Oakland, Maryland		24a. REC'D BY REGISTRAR FEB 2 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

THE STATE
MAINE

MAINE STATE DEPARTMENT OF HEALTH
DIVISION OF PUBLIC HEALTH AND RECORDS
010 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: James E. [illegible]
2. Date of Death: 10-1-51
3. Place of Death: Home
4. Age: 68 Years
5. Sex: Male
6. Race: White
7. Occupation: Farmer
8. Cause of Death: Heart Disease
9. Manner of Death: Natural
10. Signature of Examiner: [illegible]
11. Date of Certificate: 10-1-51
12. Registrar's Name: [illegible]
13. Registrar's Address: [illegible]
14. Registrar's Signature: [illegible]
15. Date of Registration: 10-1-51

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

674

00669

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Gorman		c. LENGTH OF STAY IN 1b 68 yrs.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Gorman		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1/2 mi. West Gorman	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		d. STREET ADDRESS 1/2 Mi. West Gorman	
3. NAME OF DECEASED (Type or print) First Carl Middle Alvin Last Martin		4. DATE OF DEATH Month January Day 1 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/12/1892
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months 6 Days 1 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	
11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Christian Martin		14. MOTHER'S MAIDEN NAME Eliza Roth	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 232-60-5162	
17. INFORMANT Address Mrs. Pearl Martin Gorman, W. Va.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA DUE TO 163X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PARC. WOUND OF LUNGS, GENERALIZED DUE TO 6 mos (c) 6 mos		INTERVAL BETWEEN ONSET AND DEATH 1 WEEK	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 1:00A		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov 15 1960 to Dec 29 1960, that (I) (we) last saw the deceased alive on Dec 15 1960, and that death occurred at 1:00A M, from the causes and on the date stated above.			
22a. SIGNATURE James H. Feaster Jr. M.D.		22b. DATE SIGNED 1-2-61	
22c. PHYSICIAN'S NAME (Type) James H. Feaster Jr., M. D.		22d. ADDRESS Oakland, Md.	
23a. BURIAL, CREMATION, or other disposition (Specify) Burial		23b. DATE THEREOF 1/4/1961	
23c. NAME OF CEMETERY OR CREMATORY Red House Cemetery		23d. LOCATION (City, town, or county) (State) Garrett County, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE H. C. Leighton		25a. REC'D BY REGISTRAR Oakland, Md.	
25b. REGISTRAR'S SIGNATURE Arthur L. Thomas		25c. DATE JAN 6 '61	

STATE OF TEXAS
COUNTY OF DALLAS

1902

Witness my hand and seal of office this 1st day of January, 1902.

Notary Public in and for the State of Texas.

Notary Public in and for the State of Texas.

My commission expires this 1st day of January, 1902.

My commission expires this 1st day of January, 1902.

My commission expires this 1st day of January, 1902.

Witness my hand and seal of office this 1st day of January, 1902.

Witness my hand and seal of office this 1st day of January, 1902.

My commission expires this 1st day of January, 1902.

My commission expires this 1st day of January, 1902.

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My commission expires this 1st day of January, 1902.

My commission expires this 1st day of January, 1902.

My commission expires this 1st day of January, 1902.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

675 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 00679

1. PLACE OF DEATH o. COUNTY GARRETT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE MO b. COUNTY RAY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GRANTSVILLE, MD				c. LENGTH OF STAY IN 1b TRAN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RICHMOND	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS 62X-3		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CLARENCE Middle WILLIAM Last McFARLAND				4. DATE OF DEATH Month JAN. Day 16 Year 1961			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APR. 17 1898	
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months 7 Days 2		IF UNDER 24 HRS. Hours 7 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED FARMER				10b. KIND OF BUSINESS OR INDUSTRY OWN FARM		11. BIRTHPLACE (State or foreign country) ATHERTON, MO	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME GEORGE W McFARLAND				14. MOTHER'S MAIDEN NAME ANN COFFMAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT C. H. McFarland Address 2714 N. Oakland St. ARL. 7, VA	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BROKEN NECK DUE TO 819X Conditions, if any, which gave rise to immediate cause (b) CRUSHED CHEST (c) 5 mins. DUE TO 5 mins. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) AUTO STRUCK Bridge Rt 40 near Grantsville Garra. Tnd.			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 1-16 1961		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) (County) (State) GRANTSVILLE Garra. Tnd.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE James H. Feaster, Jr.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) James H. Feaster, Jr. M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1/25/61		22c. NAME OF CEMETERY OR CREMATORY RICHMOND		22d. LOCATION (City, town, or county) (State) RICHMOND, RAY Co., MO	
23. FUNERAL DIRECTOR'S SIGNATURE Don J. Newman, Grantsville, Maryland				24. REC'D BY REGISTRAR DATE JAN 19 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00671

676

1. PLACE OF DEATH o. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE W.Va. b. COUNTY Mineral			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland				c. LENGTH OF STAY IN 1b 2 Yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cuppett Nursing Home				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Keyser 85X-3			
				d. STREET ADDRESS 40 Spring			
3. NAME OF DECEASED (Type or print) Ella C. Moorehead				4. DATE OF DEATH Month Jan. Day 25 Year 1961			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 27, 1887		9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Harry Richter				14. MOTHER'S MAIDEN NAME Ellen Cavey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Percy Combs-Keyser, W.Va.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal pneumonia 331X DUE TO Paralysis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Complete Deafness & Blindness following CVA (c) Malnutrition - Senility							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from August , 19 58 , to January , 19 61 , that I last saw the deceased alive on Jan 18 , 19 61 , and that death occurred at 8:45 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 25 ALDER ST. OAKLAND MD DATE SIGNED 1/26/61							
ACTUAL SIGNATURE E. J. Baumgartner		M.D. 25 ALDER ST. OAKLAND MD					
PHYSICIAN'S NAME (Type) E. J. BAUMGARTNER							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/28/61	22c. NAME OF CEMETERY OR CREMATORY Philos		22d. LOCATION (City, town, or county) Westernport		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE E. J. Baumgartner		ADDRESS Westernport, Md.		24a. REC'D BY REGISTRAR DATE JAN 31 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

676

MAILED
RECORDED
INDEXED

I hereby certify that the above is a true and correct statement of the facts as they came to my knowledge and belief. Signature of Registrar: _____ Date: _____		I hereby certify that the above is a true and correct statement of the facts as they came to my knowledge and belief. Signature of Physician: _____ Date: _____	
Name of Deceased: _____ Sex: _____ Age: _____ Race: _____		Date of Death: _____ Time of Death: _____ Place of Death: _____	
Cause of Death: _____ Immediate Cause: _____ Remote Cause: _____		Manner of Death: _____ (Natural, Accidental, Suicidal, Homicidal, Undetermined)	
Name of Informant: _____ Relationship to Deceased: _____		Name of Physician: _____ Address: _____	
Name of Burial Place: _____ Name of Undertaker: _____		Name of Hospital: _____ Name of Doctor: _____	
Name of Coroner: _____ Name of Jury: _____		Name of Medical Examiner: _____ Name of Pathologist: _____	
Name of Registrar: _____ Name of Clerk: _____		Name of Assistant Registrar: _____ Name of Assistant Clerk: _____	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

677

CERTIFICATE OF DEATH

Reg. Dist. No.

00672

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY X Grant Mineral			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland				c. LENGTH OF STAY IN 1b 1 day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garrett County Memorial Hospital				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elk Garden			
				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Annie Middle Belle Last Paugh		4. DATE OF DEATH Month January Day 30 Year 19 61			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 21, 1883		9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Bedford, Pennsylvania		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME John Dishong				14. MOTHER'S MAIDEN NAME Hannah Jacob			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. ---		17. INFORMANT Mable Greaser (Daughter)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 days 10 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 28 Dec., 1960, to 30 Jan., 1961, that I last saw the deceased alive on 29 Jan., 1961, and that death occurred at 6:45 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Andrew E. Mance M.D.				ADDRESS (Street, city or town, state) Oakland, Md.		DATE SIGNED 30 Jan 61	
PHYSICIAN'S NAME (Type) Andrew E. Mance, M. D.				Oakland, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/2/1961		22c. NAME OF CEMETERY OR CREMATORY I.O.O.F. Cemetery		22d. LOCATION (City, town, or county) (State) Elk Garden, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Mildred Sharpless				ADDRESS Oakland, Md.		24a. REC'D BY REGISTRAR Blaine, W. Va.	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		DATE FEB 6 '61	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESSES	
JAMES H. BROWN		45		M		W		C		M		H		C		C		JAN 15 1900		BALTIMORE		DIPHTHERIA		NATURAL		J. H. BROWN		J. H. BROWN		J. H. BROWN	
BORN		JAN 15 1855		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
FATHER		J. H. BROWN		MOTHER		J. H. BROWN		SISTER		J. H. BROWN		BROTHER		J. H. BROWN		SISTER		J. H. BROWN		BROTHER		J. H. BROWN		SISTER		J. H. BROWN		BROTHER		J. H. BROWN	
MARRIED		JAN 15 1880		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
OCCUPATION		C		C		C		C		C		C		C		C		C		C		C		C		C		C		C	
RESIDENCE		C		C		C		C		C		C		C		C		C		C		C		C		C		C		C	
DATE OF DEATH		JAN 15 1900		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
PLACE OF DEATH		C		C		C		C		C		C		C		C		C		C		C		C		C		C		C	
CAUSE OF DEATH		DIPHTHERIA		NATURAL		DIPHTHERIA		NATURAL		DIPHTHERIA		NATURAL		DIPHTHERIA		NATURAL		DIPHTHERIA		NATURAL		DIPHTHERIA		NATURAL		DIPHTHERIA		NATURAL		DIPHTHERIA	
MANNER OF DEATH		NATURAL		DIPHTHERIA		NATURAL		DIPHTHERIA		NATURAL		DIPHTHERIA		NATURAL		DIPHTHERIA		NATURAL		DIPHTHERIA		NATURAL		DIPHTHERIA		NATURAL		DIPHTHERIA		NATURAL	
SIGNATURE OF PHYSICIAN		J. H. BROWN		J. H. BROWN		J. H. BROWN		J. H. BROWN		J. H. BROWN		J. H. BROWN		J. H. BROWN		J. H. BROWN		J. H. BROWN		J. H. BROWN		J. H. BROWN		J. H. BROWN		J. H. BROWN		J. H. BROWN		J. H. BROWN	
SIGNATURE OF REGISTRAR		J. H. BROWN		J. H. BROWN		J. H. BROWN		J. H. BROWN		J. H. BROWN		J. H. BROWN		J. H. BROWN		J. H. BROWN		J. H. BROWN		J. H. BROWN		J. H. BROWN		J. H. BROWN		J. H. BROWN		J. H. BROWN		J. H. BROWN	
SIGNATURE OF WITNESSES		J. H. BROWN		J. H. BROWN		J. H. BROWN		J. H. BROWN		J. H. BROWN		J. H. BROWN		J. H. BROWN		J. H. BROWN		J. H. BROWN		J. H. BROWN		J. H. BROWN		J. H. BROWN		J. H. BROWN		J. H. BROWN		J. H. BROWN	

DEATH CERTIFICATE

DEATH CERTIFICATE

CERTIFICATE OF DEATH

Reg. Dist. No.

00673

678

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GRANTSVILLE, MD				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GRANTSVILLE, MD			
c. LENGTH OF STAY IN 1b 14 YRS				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) ORPHA First CATHERINE Middle RODAMER Last				4. DATE OF DEATH JAN. Month 15 Day 1961 Year			
5. SEX FEMALE		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Approx. 75 yrs.	
9. AGE (In years lost birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALES LADY				10b. KIND OF BUSINESS OR INDUSTRY BENDER WATCH		11. BIRTHPLACE (State or foreign country) SOMERSET Co., PA	
12. CITIZEN OF WHAT COUNTRY? U.S.A							
13. FATHER'S NAME SIMON L MAUST				14. MOTHER'S MAIDEN NAME SAVILLA FOLK			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. INFORMANT Charles A. Rodamer, Harrisonburg, Va. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 157X Generalized anasarca DUE TO (b) Abdominal carcinomatosis DUE TO (c) Primary carcinoma of pancreas Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan 15, 1960 to Jan 15, 1961 , that I last saw the deceased alive on Jan 14, 1961 , and that death occurred at 6:15 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Grantsville, Md. DATE SIGNED 1/14/61 ACTUAL SIGNATURE A. Paige Strong M.D. Grantsville, Md. PHYSICIAN'S NAME (Type) A. Paige Strong							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1/17/61		22c. NAME OF CEMETERY OR CREMATORY GRANTSVILLE		22d. LOCATION (City, town, or county) (State) GRANTSVILLE GARRETT CO MD	
23. FUNERAL DIRECTOR'S SIGNATURE Don Newman, Grantsville, Md. ADDRESS				24a. REC'D BY REGISTRAR JAN 19 '61 DATE		24b. REGISTRAR'S SIGNATURE Arthur L. Kneib	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

State of New York
County of New York
City of New York

On the 10th day of June 1920
at New York City
I, the undersigned, a duly qualified physician,
do hereby certify that

the within named person
has died

of the following disease or diseases
as shown by the following history and
physical examination

and the following post-mortem examination
and the following laboratory examination

and the following other examination
and the following other examination

and the following other examination
and the following other examination

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

679

00674

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland. b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Swanton,		c. LENGTH OF STAY IN 1b 66 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R. D. #1 Swanton, Md.		d. STREET ADDRESS R. D. #1	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Bessie Middle Frances Last Sharpless		4. DATE OF DEATH Month January Day 26, Year 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 1, 1894
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months 66 Days 66 Hours 66 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Francis R. Sharpless		14. MOTHER'S MAIDEN NAME Elizabeth Fulmer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Mrs. Gladys Tasker		Address R.D.#1 Swanton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction Acute 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) 6-10 Years		INTERVAL BETWEEN ONSET AND DEATH 15-20 Minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from December 26 1960 to January 26 1961 , that (I) (we) last saw the deceased alive on November 19 1960 , and that death occurred at 10:30 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Herbert H. Leighton		22b. DATE SIGNED 28 Jan 61	
22c. PHYSICIAN'S NAME (Type) Herbert H. Leighton, M. D.		22d. ADDRESS Oakland, Maryland.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/29/1961	
23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery		23d. LOCATION (City, town, or county) (State) R. D. #1 Swanton, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Mildred Sharpless		ADDRESS Blaine, W. Va.	
25a. REC'D BY REGISTRAR FEB 1 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Harris	

Amy Mildred Sharpless

